VA SPONSORED AND NON VA-SPONSORED CLINICAL TRAINEE WITHOUT COMPENSATION (WOC) CHECKLIST

This checklist identifies all items that must be completed for new trainees to obtain an initial WOC appointment letter, badge, and computer access codes from the VA Eastern Colorado Health Care System (ECHCS). The WOC appointment letter must be established and current for WOC personnel to work at any ECHCS facility. The WOC appointment letter may be valid for the entire duration of your training program or less, depending on the anticipated training program and/or graduation end date that is provided by your Educational Institution to the VA on the Trainee Qualifications & Credentials Verification Letter (TQCVL). Please complete the highlighted sections of this checklist electronically as there is an additional requirement for non-citizens or non-US born citizens to complete.

Please note: This entire process must be completed for returning trainees if they allow their WOC appointment to expire before requesting an extension for a new WOC appointment. Trainees needing an extension on their WOC appointment should coordinate with their Educational Institution's Program Coordinator and/or VA Point of Contact (POC) to submit an updated TQCVL, VHA mandatory training for trainees (MTT) certificates, and WOC Extension Request coversheet to VA Human Resources.

In accordance with VA Handbook 5005, Part II, Chapter 3, approval for Without Compensation (WOC) Appointment is requested for the following applicant to be assigned to the VA Eastern Colorado Health Care System (ECHCS).

NAME: _____

DATE OF BIRTH: _____ **COUNTRY OF BIRTH:** _____

SOCIAL SECURITY NUMBER: _____

US CITIZEN: ☐ **YES** ☐ **NO – Fill out Non-Citizen Memo**

☐ **NATURALIZED US CITIZEN – Fill out Verification of Naturalization**

DATE OF BADGE OFFICE VISIT TO COMPLETE FINGERPRINTS: _____

APPOINTMENT IS LESS THAN 180 DAYS IN AN AGGREGATE YEAR: ☒ **YES** ☐ **NO – Fill out E-QIP Enrollment**

PLEASE SUBMIT CHECKED ITEMS BELOW WITH THIS CHECKLIST TO COMPLETE YOUR PACKET

- ☒ **Application for Health Professions Trainees (VA Form 10-2850D)**
- ☒ **Declaration for Federal Employment (OF-306)**
- ☒ **Employment Eligibility Verification (USCIS Form I-9, section 1)**
- ☒ **Computer Access Request Form**
- ☐ **E-QIP Enrollment form (if applicable)**
- ☒ **VHA Mandatory Training for Trainees Certificates**
- ☒ **Random Drug Testing Notification and Acknowledgment**
- ☒ **Local Policy Acknowledgment** (Patient Abuse, Employee/Patient Relationships, & Rules of Behavior)
- ☐ **Non-Citizen Memo (if applicable)**
- ☐ **Verification of Naturalization (if applicable)**

NOTE: Required Identity and/or Employment Authorization documents must be presented at time of VA HR in-processing/signing of WOC appointment letter. Non-citizens will need to present a Valid Visa. Naturalized US citizens will need to present original document for Verification of Naturalization.

THIS SECTION TO BE COMPLETED BY VA POC FOR ON-BOARDING

SERVICE/TRAINING PROGRAM: Internal Medicine Residency Program

PRIMARY POC: Virginia Youngstrom **PHONE:** 720-723-4665

SECONDARY POC: _____ **PHONE:** _____

FOLLOWING CHECKED BOXES INDICATE RECEIPT OF REQUIRED WOC DOCUMENTS BY VA POC. VA POC SIGNATURE CONFIRMS COMPLETE DOCUMENT SUBMISSION TO VA HR.

- ☐ **Applicant WOC Packet - includes DEO/DEO Designee Signature(s)**
- ☐ **VHA Mandatory Training for Trainees Certificate**
- ☐ **TQCVL - includes RMR VAMC Director Signature**

VA POC SIGNATURE: _____

OMB Number: 2900-0205
Estimated Burden: 30 minutes

Department of Veterans Affairs

APPLICATION FOR HEALTH PROFESSIONS TRAINEES

SEE LAST PAGE FOR PAPERWORK REDUCTION ACT, PRIVACY ACT AND INFORMATION ABOUT DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER

INSTRUCTIONS: Please submit this application furnishing all information in sufficient detail to enable the Department of Veterans Affairs (VA) to determine your eligibility for appointment. Type or print in ink. If additional space is needed, please attach a separate sheet and refer to items being answered by number. Applications for clinical training programs may require additional information. All information required by the training program to which you are applying, as well as information requested on all application forms, must be included.

VA must protect the safety of our patients. Therefore, at some point in the appointment process, you will be asked questions about your physical and mental health. This includes questions as to whether you have received tuberculin testing, hepatitis B vaccinations or any other vaccinations.

1A. NAME (Last, First, Middle)		1B. OTHER NAMES USED	
2. PRESENT ADDRESS (Include ZIP Code)		3A. PRIMARY PHONE (Include area code) 3B. ALTERNATE PHONE (Include area code)	
4. SOCIAL SECURITY NUMBER	5A. PRIMARY EMAIL ADDRESS	5B. ALTERNATE EMAIL ADDRESS	6. DATE OF BIRTH (mm/dd/yyyy)
7A. VA TRAINING FACILITY (City, State)	7B. VA TRAINING START DATE (mm/yyyy) ☐ UNKNOWN	7C. VA TRAINING END DATE (mm/yyyy) ☐ UNKNOWN	

II - U.S. MILITARY DUTY STATUS

8A. ARE YOU NOW IN U.S. MILITARY?	8B. ARE YOU IN THE RESERVES OR NATIONAL GUARD?	8C. BRANCH OF SERVICE
☐ YES *(If YES, complete 8c)* ☐ NO	☐ YES *(If YES, complete 8c)* ☐ NO	

III - CITIZENSHIP

9A. CITIZENSHIP	9B. COUNTRY OF CITIZENSHIP
☐ U.S. CITIZEN BY BIRTH ☐ NATURALIZED U.S. CITIZEN ☐ NOT A U.S. CITIZEN (Complete item 9B)	

NOTE: Complete items 10A, 10B, 10C, or 10D ONLY if you are NOT a U.S. citizen.

10A. IMMIGRANT	10B. EXCHANGE VISITOR		10C. OTHER NON-IMMIGRANT		10D. FORM DS2019
"A" NUMBER	VISA TYPE	VISA NUMBER	VISA TYPE	VISA NUMBER	DO YOU HAVE A VALID DS2019? ☐ YES ☐ NO
DATE	ISSUE DATE	EXPIRATION DATE	ISSUE DATE	EXPIRATION DATE	DATE OF LAST VALIDATION (MM/DD/YYYY)

IV- THIS SECTION TO BE COMPLETED BY DESIGNATED EDUCATION OFFICER (DEO) OR DESIGNEE

11A. The trainee has met all of the criteria of the Trainee Qualifications & Credentials Verification Letter (TQCVL).	☐ YES ☐ NO
11B. Incomplete items on the TQCVL have been addressed and resolved.	☐ YES ☐ NO
11C. Special attention has been given to the following items from the application forms.	
11D. Comments:	
11E. This applicant has been approved for appointment.	☐ YES ☐ NO
11F. Comments:	

12A. SIGNATURE OF FACILITY DESIGNATED EDUCATION OFFICER OR DESIGNEE	12B. TITLE	12C. DATE

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER

V- LICENSE, CERTIFICATION, OR REGISTRATION IN CURRENT CLINICAL PROFESSION

13A. LIST ALL LICENSES, CERTIFICATIONS,AND REGISTRATIONS, INCLUDING THE DRUG ENFORCEMENT AGENCY (DEA), THAT YOU HAVE NOW OR HAVE HAD AS A HEALTH PROFESSIONAL, I.E. MEDICAL, NURSING, PHARMACY, ETC.	13B. STATE ISSUING LICENSE	13C. LICENSE, CERTIFICATION OR REGISTRATION NUMBER	13D. EXPIRATION DATE (MM/DD/YYYY)

VI- LICENSE, CERTIFICATION, OR REGISTRATION IN OTHER/PREVIOUS CLINICAL PROFESSION(S)

14A. LIST ALL LICENSES, CERTIFICATIONS, AND REGISTRATIONS, INCLUDING DEA, THAT YOU HAVE EVER HAD AS A HEALTH PROFESSIONAL, I.E. MEDICAL, NURSING, PHARMACY, ETC.	14B. STATE ISSUING LICENSE	14C. LICENSE, CERTIFICATION OR REGISTRATION NUMBER	14D. EXPIRATION DATE (MM/DD/YYYY)

15. ENTER YOUR NATIONAL PROVIDER IDENTIFIER (NPI)

The following two questions apply to both your current health profession and any prior health profession.

16. DO YOU HAVE PENDING, OR HAVE YOU EVER HAD ANY LICENSE, CERTIFICATION, OR REGISTRATION TO PRACTICE (INCLUDING DEA CERTIFICATE) REVOKED, SUSPENDED, DENIED, RESTRICTED, OR PLACED ON A PROBATIONARY STATUS, OR HAVE YOU EVER VOLUNTARILY RELINQUISHED A LICENSE, CERTIFICATION, OR REGISTRATION IN LIEU OF FORMAL ACTION? ☐ YES - EXPLAIN IN PART XI ☐ NO

17. DO YOU HAVE PENDING, OR HAVE YOU EVER HAD CLINICAL PRIVILEGES AT ANY HEALTH CARE INSTITUTION OR AGENCY REVOKED, SUSPENDED, DENIED, RESTRICTED, LIMITED, OR PLACED ON A PROBATIONARY STATUS, OR HAVE YOU EVER VOLUNTARILY RELINQUISHED CLINICAL PRIVILEGES IN LIEU OF FORMAL ACTION? ☐ YES - EXPLAIN IN PART XI ☐ NO

VII - EDUCATION AND TRAINING AFTER HIGH SCHOOL THROUGH GRADUATE / PROFESSIONAL SCHOOL (Continue in Part XI if necessary)

18A. NAME OF SCHOOL	18B. ADDRESS (City, State, and Zip Code)	18C. START DATE (MM/YY)	18D. (EXPECTED) COMPLETION DATE (MM/YY)	18E. DIPLOMA, DEGREE, OR CERTIFICATE AWARDED OR IN PROGRESS	18F. MAJOR FIELD OF STUDY

VIII - GRADUATES OF AN INTERNATIONAL MEDICAL SCHOOL

19A. ARE YOU A GRADUATE OF AN INTERNATIONAL MEDICAL SCHOOL? ☐ YES ☐ NO	19B. EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) CERTIFICATE NUMBER	19C. ECFMG CERTIFICATE DATE

IX- INTERNSHIP, RESIDENCY AND FELLOWSHIP TRAINING

20A. NAME OF HOSPITAL OR INSTITUTION	20B. ADDRESS (City, State and ZIP Code)	20C. SPECIALTY	20D. START DATE (MM/YY)	20E.(EXPECTED) COMPLETION DATE (MM/YY)	20F. NUMBER OF MONTHS COMPLETED

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER

X - ADDITIONAL QUESTIONS

ITEM	PLACE AN 'x' IN APPROPRIATE SPACE. IF YES, EXPLAIN DETAILS IN PART XI	YES	NO
21	AS A PARTICIPANT IN THE MEDICARE AND MEDICAID PROGRAMS, HAVE YOU EVER BEEN CONVICTED OF OR INVESTIGATED FOR MAKING FALSE, FICTITIOUS, OR FRAUDULENT STATEMENTS, REPRESENTATIONS, WRITINGS, OR DOCUMENTS REGARDING THE DELIVERY OF OR PAYMENT FOR HEALTH CARE BENEFITS, ITEMS OR SERVICES THAT WOULD BE IN VIOLATION OF THE CRIMINAL FALSE CLAIMS ACT?	☐	☐
22	ARE YOU NOW, OR HAVE YOU EVER BEEN, INVOLVED IN ADMINISTRATIVE, PROFESSIONAL, OR JUDICIAL PROCEEDINGS IN WHICH MALPRACTICE ON YOUR PART WAS ALLEGED? If yes, give details in Part XI, including name of action or proceedings, date filed, court or reviewing agency, and the status or outcome of the case concerning those allegations. Please also provide your explanation of what occurred. As a provider of health care services, the VA has an obligation to exercise reasonable care in determining that applicants are properly qualified. It is recognized that many allegations of professional malpractice are proven groundless. Any conclusion concerning your answer as it relates to professional qualifications will be made only after a full evaluation of the circumstances involved.	☐	☐
23	Do you need accommodations to perform the procedures and essential functions of the training position for which you have applied?	☐	☐

XI - REMARKS

ITEM NO.	(Include additional information requested in items above. Be sure to indicate item number on Form to which the comment refers.)

XII - CERTIFICATION

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL OF MY STATEMENTS ARE TRUE, CORRECT, COMPLETE, AND MADE IN GOOD FAITH.

NOTE: A false statement on any part of your application may be grounds for not hiring you, or for terminating you after you begin work. Also, you may be punished by fine or imprisonment (U.S. Code, Title 18, Section 1001).

24A. SIGNATURE OF APPLICANT *(Sign in ink)*	24B. DATE *(mm/dd/yyyy)*

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER

AUTHORIZATION FOR RELEASE OF INFORMATION

In order for the Department of Veterans Affairs (VA) to assess and verify my educational background, professional qualifications and suitability for employment, I:

- ☐ Authorize VA to make inquiries about me to current and previous employers, educational institutions, state licensing boards, professional liability insurance carriers, other professional organizations or persons, agencies, organizations, or institutions listed by me as references, and to any other sources which VA may deem appropriate or be referred by those contacted;
- ☐ Authorize release of such information and copies of related records and documents to VA officials;
- ☐ Release from liability all those who provide information to VA in good faith and without malice in response to such inquiries;
- ☐ Authorize VA to disclose to such persons, employers, institutions, boards, or agencies identifying and other information about me to enable VA to make such inquiries; and
- ☐ Authorize VA to share any information about me with the affiliated institution or training program official.

SIGNATURE OF APPLICANT *(Sign in ink)*	DATE

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE

Public reporting burden for this collection of information is estimated to average 30 minutes, including the time for reviewing instructions, searching existing data sources, gathering data, completing, and reviewing the information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to VA Clearance Officer (005R1B), 810 Vermont Avenue NW, Washington, DC 20420. Do not send applications to this address.

AUTHORITY: The information requested on this form and Authorization for Release of Information is solicited under Title 38, United States Code, Chapters 73 and 74.

PURPOSES AND USES: The information requested on the application is collected to determine your qualifications and suitability for appointment to a VA clinical training program. If you are appointed by VA, the information will be used to make pay and benefit determinations and in personnel administration processes carried out in accordance with established regulations and systems of records.

ROUTINE USES: Information on the form may be released without your prior consent outside the VA to another federal, state or local agency. It may be used to check the National Practitioner Health Integrity and Protection Data Bank (HIPDB) or the List of Excluded Individuals and Entities (LEIE) maintained by Health and Human Services (HHS), Office of Inspector General (OIG), or to verify information with state licensing boards and other professional organizations or agencies to assist VA in determining your suitability for a clinical training appointment. This information may also be used periodically to verify, evaluate, and update your clinical privileges, credentials, and licensure status, to report apparent violations of law, to provide statistical data, or to provide information to a Congressional office in response to an inquiry made at your request. Such information may be released without your prior consent to federal agencies, state licensing boards, or similar boards or entities, in connection with the VA's reporting of information concerning your separation or resignation as a professional staff member under circumstances which raise serious concerns about your professional competence. Information concerning payments related to malpractice claims and adverse actions which affect clinical privileges also may be released to state licensing boards and the National Practitioner Data Bank. Information will be stored in a confidential and secure VA database for purposes of processing your application and may be verified through a computer matching program. Information from this form may also be used to survey you regarding employment opportunities in VA and to solicit you perceptions about your clinical training experiences at VA and non-VA facilities.

EFFECTS OF NON-DISCLOSURE: See statement below concerning disclosure of your social security number. Completion of this form is mandatory for consideration of your application for a clinical training position in VA; failure to provide this information may make impossible the proper application of Civil Service rules and regulations and VA personnel policies and may prevent you from obtaining employment, employee benefits, or other entitlements.

INFORMATION REGARDING DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER UNDER PUBLIC LAW 93-579 SECTION 7(b)

Disclosure of your Social Security Number (SSN) is mandatory to obtain the employment and benefits that you are seeking. Solicitation of the SSN is authorized under provisions of Executive Order 9397 dated November 22, 1943. The SSN is used as an identifier throughout your Federal career. It will be used primarily to identify your records. The SSN also will be used by Federal agencies in connection with lawful requests for information about you from former employers, educational institutions, and financial or other organizations. The information gathered through the use of the number will be used only as necessary in personnel administration processes carried out in accordance with established regulations and published notices of systems of records, 'Applicants for Employment' under Title 38, U.S.C.-VA (02VA135), in the 2003 Compilation of Privacy Act Issuances. The SSN will also be used for the selection of persons to be included in statistical studies of personnel management matters. The use of the SSN is necessary because of the large number of Federal employees and applicants with identical names and birth dates whose identities can only be distinguished by the SSN.

Declaration for Federal Employment*

(*This form may also be used to assess fitness for federal contract employment)

Form Approved:
OMB No. 3206-0182

Instructions

The information collected on this form is used to determine your acceptability for Federal and Federal contract employment and your enrollment status in the Government's Life Insurance program. You may be asked to complete this form at any time during the hiring process. Follow instructions that the agency provides. If you are selected, before you are appointed you will be asked to update your responses on this form and on other materials submitted during the application process and then to recertify that your answers are true.

All your answers must be truthful and complete. **A false statement on any part of this declaration or attached forms or sheets may be grounds for not hiring you, or for firing you after you begin work. Also, you may be punished by a fine or imprisonment (U.S. Code, title 18, section 1001).**

Either type your responses on this form or print clearly in dark ink. If you need additional space, attach letter-size sheets (8.5" X 11"). Include your name, Social Security Number, and item number on each sheet. We recommend that you keep a photocopy of your completed form for your records.

Privacy Act Statement

The Office of Personnel Management is authorized to request this information under sections 1302, 3301, 3304, 3328, and 8716 of title 5, U. S. Code. Section 1104 of title 5 allows the Office of Personnel Management to delegate personnel management functions to other Federal agencies. If necessary, and usually in conjunction with another form or forms, this form may be used in conducting an investigation to determine your suitability or your ability to hold a security clearance, and it may be disclosed to authorized officials making similar, subsequent determinations.

Your Social Security Number (SSN) is needed to keep our records accurate, because other people may have the same name and birth date. Public Law 104-134 (April 26, 1996) asks Federal agencies to use this number to help identify individuals in agency records. Giving us your SSN or any other information is voluntary. However, if you do not give us your SSN or any other information requested, we cannot process your application. Incomplete addresses and ZIP Codes may also slow processing.

ROUTINE USES: Any disclosure of this record or information in this record is in accordance with routine uses found in System Notice OPM/GOVT-1, General Personnel Records. This system allows disclosure of information to: training facilities; organizations deciding claims for retirement, insurance, unemployment, or health benefits; officials in litigation or administrative proceedings where the Government is a party; law enforcement agencies concerning a violation of law or regulation; Federal agencies for statistical reports and studies; officials of labor organizations recognized by law in connection with representation of employees; Federal agencies or other sources requesting information for Federal agencies in connection with hiring or retaining, security clearance, security or suitability investigations, classifying jobs, contracting, or issuing licenses, grants, or other benefits; public and private organizations, including news media, which grant or publicize employee recognitions and awards; the Merit Systems Protection Board, the Office of Special Counsel, the Equal Employment Opportunity Commission, the Federal Labor Relations Authority, the National Archives and Records Administration, and Congressional offices in connection with their official functions; prospective non-Federal employers concerning tenure of employment, civil service status, length of service, and the date and nature of action for separation as shown on the SF 50 (or authorized exception) of a specifically identified individual; requesting organizations or individuals concerning the home address and other relevant information on those who might have contracted an illness or been exposed to a health hazard; authorized Federal and non-Federal agencies for use in computer matching; spouses or dependent children asking whether the employee has changed from a self-and-family to a self-only health benefits enrollment; individuals working on a contract, service, grant, cooperative agreement, or job for the Federal government; non-agency members of an agency's performance or other panel; and agency-appointed representatives of employees concerning information issued to the employees about fitness-for-duty or agency-filed disability retirement procedures.

Public Burden Statement

Public burden reporting for this collection of information is estimated to vary from 5 to 30 minutes with an average of 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing this burden, to the U.S. Office of Personnel Management, Reports and Forms Manager (3206-0182), Washington, DC 20415-7900. The OMB number, 3206-0182, is valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

Declaration for Federal Employment*

Form Approved:
OMB No. 3206-0182

(*This form may also be used to assess fitness for federal contract employment)

GENERAL INFORMATION

1. **FULL NAME** (Provide your full name. If you have only initials in your name, provide them and indicate "Initial only". If you do not have a middle name, indicate "No Middle Name". If you are a "Jr.," "Sr.," etc. enter this under Suffix. First, Middle, Last, Suffix)

♦

2. SOCIAL SECURITY NUMBER	3a. PLACE OF BIRTH (Include city and state or country)
♦	♦

3b. ARE YOU A U.S. CITIZEN?	4. DATE OF BIRTH (MM / DD / YYYY)
☐ YES ☐ NO (If "NO", provide country of citizenship) ♦	♦
5. OTHER NAMES EVER USED (For example, maiden name, nickname, etc)	**6. PHONE NUMBERS** (Include area codes)
♦	Day ♦
♦	Night ♦

Selective Service Registration

If you are a male born after December 31, 1959, and are at least 18 years of age, civil service employment law (5 U.S.C. 3328) requires that you must register with the Selective Service System, unless you meet certain exemptions.

7a. Are you a male born after December 31, 1959? ☐ YES ☐ NO (If "NO", proceed to 8.)

7b. Have you registered with the Selective Service System? ☐ YES (If "YES", proceed to 8.) ☐ NO (If "NO", proceed to 7c.)

7c. If "NO," describe your reason(s) in item 16.

Military Service

8. Have you ever served in the United States military? ☐ YES (If "YES", provide information below) ☐ NO

If you answered "YES," list the branch, dates, and type of discharge for all active duty.
If your only active duty was training in the Reserves or National Guard, answer "NO."

Branch	From (MM/DD/YYYY)	To (MM/DD/YYYY)	Type of Discharge

Background Information

For all questions, provide all additional requested information under item 16 or on attached sheets. The circumstances of each event you list will be considered. However, in most cases you can still be considered for Federal jobs.

For questions 9,10, and 11, your answers should include convictions resulting from a plea of *nolo contendere* (no contest), but omit (1) traffic fines of $300 or less, (2) any violation of law committed before your 16th birthday, (3) any violation of law committed before your 18th birthday if finally decided in juvenile court or under a Youth Offender law, (4) any conviction set aside under the Federal Youth Corrections Act or similar state law, and (5) any conviction for which the record was expunged under Federal or state law .

9. During the last 7 years, have you been convicted, been imprisoned, been on probation, or been on parole? (Includes felonies, firearms or explosives violations, misdemeanors, and all other offenses.) *If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.* ☐ YES ☐ NO

10. Have you been convicted by a military court-martial in the past 7 years? *(If no military service, answer "NO.") If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the military authority or court involved.* ☐ YES ☐ NO

11. Are you currently under charges for any violation of law? *If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.* ☐ YES ☐ NO

12. During the last 5 years, have you been fired from any job for any reason, did you quit after being told that you would be fired, did you leave any job by mutual agreement because of specific problems, or were you debarred from Federal employment by the Office of Personnel Management or any other Federal agency? *If "YES," use item 16 to provide the date, an explanation of the problem, reason for leaving, and the employer's name and address.* ☐ YES ☐ NO

13. Are you delinquent on any Federal debt? (Includes delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults of Federally guaranteed or insured loans such as student and home mortgage loans.) *If "YES," use item 16 to provide the type, length, and amount of the delinquency or default, and steps that you are taking to correct the error or repay the debt.* ☐ YES ☐ NO

Declaration for Federal Employment*

(*This form may also be used to assess fitness for federal contract employment)

Form Approved:
OMB No. 3206-0182

Additional Questions

14. Do any of your relatives work for the agency or government organization to which you are submitting this form? (Include: father, mother, husband, wife, son, daughter, brother, sister, uncle, aunt, first cousin, nephew, niece, father-in-law,mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepfather, stepmother, stepson, stepdaughter, stepbrother, stepsister, half brother, and half sister.) *If "YES," use item 16 to provide the relative's name,relationship, and the department, agency, or branch of the Armed Forces for which your relative works.* ☐ YES ☐ NO

15. Do you receive, or have you ever applied for, retirement pay, pension, or other retired pay based on military, Federal civilian, or District of Columbia Government service? ☐ YES ☐ NO

Continuation Space / Agency Optional Questions

16. Provide details requested in items 7 through 15 and 18c in the space below or on attached sheets. Be sure to identify attached sheets with your name, Social Security Number, and item number, and to include ZIP Codes in all addresses. If any questions are printed below, please answer as instructed *(these questions are specific to your position and your agency is authorized to ask them).*

Certifications / Additional Questions

APPLICANT: If you are applying for a position and have not yet been selected, carefully review your answers on this form and any attached sheets. When this form and all attached materials are accurate, read item 17, and complete 17a.

APPOINTEE: If you are being appointed, carefully review your answers on this form and any attached sheets, including any other application materials that your agency has attached to this form. If any information requires correction to be accurate as of the date you are signing, make changes on this form or the attachments and/or provide updated information on additional sheets, initialing and dating all changes and additions. When this form and all attached materials are accurate, read item 17, complete 17b, read 18, and answer 18a, 18b, and 18c as appropriate.

17. **I certify** that, to the best of my knowledge and belief, all of the information on and attached to this Declaration for Federal Employment, including any attached application materials, is true, correct, complete, and made in good faith . **I understand that a false or fraudulent answer to any question or item on any part of this declaration or its attachments may be grounds for not hiring me, or for firing me after I begin work, and may be punishable by fine or imprisonment. I understand** that any information I give may be investigated for purposes of determining eligibility for Federal employment as allowed by law or Presidential order. **I consent** to the release of information about my ability and fitness for Federal employment by employers, schools, law enforcement agencies, and other individuals and organizations to investigators, personnel specialists, and other authorized employees or representatives of the Federal Government. **I understand** that for financial or lending institutions, medical institutions, hospitals, health care professionals, and some other sources of information, a separate specific release may be needed, and I may be contacted for such a release at a later date.

17a. Applicant's Signature: _____ (Sign in ink) Date _____

17b. Appointee's Signature: _____ (Sign in ink) Date _____

Appointing Officer:
Enter Date of Appointment or Conversion
MM / DD / YYYY

18. **Appointee (Only respond if you have been employed by the Federal Government before):** Your elections of life insurance during previous Federal employment may affect your eligibility for life insurance during your new appointment. These questions are asked to help your personnel office make a correct determination.

18a. When did you leave your last Federal job? DATE: MM / DD / YYYY

18b. When you worked for the Federal Government the last time, did you waive Basic Life Insurance or any type of optional life insurance? ☐ YES ☐ NO ☐ DO NOT KNOW

18c. If you answered "YES" to item 18b, did you later cancel the waiver(s)? If your answer to item 18c is "NO," use item 16 to identify the type(s) of insurance for which waivers were not canceled. ☐ YES ☐ NO ☐ DO NOT KNOW

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**8.** Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Computer Access Request Form

Medical Students and Residents

Please type or block print clearly

USER DEMOGRAPHIC INFORMATION – CLINICAL TRAINEES

Last Name:	First Name:	Middle Name:
Social Security Number:	Date of Birth (Month/day/year):	
Current Street Address:		Address 2:
City:	State:	Zip:
Personal E-Mail Address:	Personal Cell Phone Number:	
UC Denver or other Professional E-Mail Address:	PAGER Number:	

PROGRAM OF STUDY:

MEDICAL STUDENT: Yes ◯ No ◯ What is your highest level of education/degree? ☐ Certification ☐ Associate Degree ☐ Baccalaureate ☐ Master ☐ PhD	**RESIDENT/FELLOW:** Yes ◯ No ◯ Indicate PGY level: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

NAME OF TRAINING PROGRAM (i.e., Internal Med., Surgery, etc…):		***TMS: Mandatory Training for Trainees*** Date last done:
Start Date of Current Program:	Anticipated End Date, of Program:	Length of Training Program (in years):
Trainee has/had a VA PIV or NON-PIV Badge? Yes ◯ No ◯	If yes, Expiration Date of VA Badge:	Trainee retained VA ID for new/upcoming VA PROGRAM: Yes ◯ No ◯
If you have ever worked/trained at any VA Facility in the country, please type name of most recent facility:		City/State:

PHYSICAL CHARACTERISTICS - Sponsoring information required by PIV PORTAL –

Any missing information will delay set up of IT accounts & new ID processing, or ID Migration, for the clinical trainee.

Foreign National: **YES** ◯ **NO** ◯	**Select the ethnic group you are most like:** A, American Indian or Alaskan Native ◯ C. Black, Non-Hispanic ◯ B. Asian or Pacific Islander ◯ D. Hispanic ◯ E. White, Non-Hispanic ◯
Male ◯ Female ◯	
Height (feet/inches): _____	Eye Color (indicate one): ☐Black ☐Blue ☐Brown ☐Green ☐Gray ☐Hazel
Weight (pounds): _____	Hair Color (indicate one): ☐Black ☐Blonde ☐Brown ☐Red ☐Gray ☐White
Where were you born (City, State/Province, Country)? _____	

For optional use by VA Administrative staff setting up user IT accounts & PIV/NON-PIV ID				
WOC application rec'd:	**Fingerprint Adjudication:**	**JIT OL request loaded:**	**NARS request loaded:**	**PIV ID Sponsored:**
HR Submission:	**Outlook account for PIV ID:**		**PIV ID User Name:**	

VHA Mandatory Training for Trainees (MTT)

- Specially developed course for Health Professions Trainees
- Training profiles and completion certificates may transfer between VA facilities
- Complete MTT once every 364 days to remain "in good standing"
    - **Attention First Time Users:** Once you complete the entire VHA MTT course, the training system will automatically assign the Refresher course to be completed a year out from the initial training. Please pay attention to the title and due date in the training system to avoid wasting time
- **Failure to complete annual training prior to due date will result in immediate loss of VA computer access and may affect use of VA badge**

How to Access Mandatory Training for Trainees (MTT)

First Time Users

Give yourself plenty of time to complete this process. After you self-enroll, TMS 2.0 needs **20 minutes** to create your account. Only after your account is created can you log in and complete the required training. **The median time to complete the VHA MTT is 90 minutes.**

1. To Self-enroll you need the following VA facility-specific information to complete the **Job Information** section.
    - VA Location: DEN
    - Trainee Type: Medical School or Physician Residency/Fellowship
    - Specialty/Discipline: Select the one that best matches your training program
    - VA Point of Contact Name: Latoya Conner
    - VA Point of Contact Email Address: Latoya.Conner@va.gov
    - VA Point of Contact Phone: 720-857-5336

2. Go to the VA Talent Management System 2.0 (TMS) **website,** https://www.tms.va.gov/SecureAuth35/

3. Click on **CREATE NEW USER**

4. Select **VETERANS HEALTH ADMINISTRATION**

5. Select **HEALTH PROFESSIONS TRAINEE**

6. Complete all **Account** and **Job Information** and click **Submit**

7. **Wait 20 minutes and then continue the steps below for Returning Users.**

If you need assistance with TMS, or already have an account, call the **VA Enterprise Service Desk (866) 496-0463**

Returning Users

1. Go to the VA Talent Management System 2.0 (TMS) **website,** https://www.tms.va.gov/SecureAuth35/

2. Your username is the email address you used to enroll. Type your email address in the "Enter Username here" box then click **Submit**

3. Elect to receive your one-time-passcode via email and click **Submit**

4. Enter the **passcode** and follow all instructions

5. Once logged into TMS 2.0 click the **Home** v and select **Learning**

6. **VHA Mandatory Training for Trainees** should appear in your To-Do list, click on the **Start Course** button to launch the training. **Make sure Pop-Up blockers are turned OFF.**

How to Access Completed Training Certificate

ALL Users

1. Once you've exited out of the completed the course, click on Home icon  at top of page
2. On the left side of page, in the "Welcome" box, click on "My Learning History"
3. Click on blue training title, a box will appear, then click on "Print Certificate" icon 

4. A separate web browser tab will populate with the training certificate that can be saved onto your computer or printed.

Department of Veterans Affairs

Memorandum

From: VHA Office of Academic Affiliations (OAA)

Subj: Random Drug Testing Notification and Acknowledgement

To: Health Professions Trainee (HPT) in a Testing Designated Positions (TDP)

1. On September 15, 1986, President Reagan signed Executive Order 12564, Drug-Free Federal Workplace, establishing a policy against the use of illegal drugs by Federal employees, whether on or off duty. In accordance with the Executive Order, VA has established a Drug-Free Workplace Program to include random testing for the use of illegal drugs by employees (to include trainees) in sensitive positions.

2. This is to notify you that as an HPT in a sensitive position you may be subject to random drug testing. The testing procedures, including the collection of a urine specimen, will be conducted in accordance with Department of Health and Human Services (HHS) Guidelines for Drug Testing Programs.

    a. The only VHA Training Programs exempt from Random Drug Testing per policy are: Clinical Pastoral Education (Chaplain), Social Work, Dietetics, Occupational Therapy, Optometry, Audiology, Speech Pathology, Non-Clinical and Administrative

3. You can be assured that the quality of testing procedures is tightly controlled, that the test used to confirm use of illegal drugs is highly reliable and that the test results will be handled with maximum respect for individual confidentiality, consistent with safety and security.

4. As a trainee subject to random drug testing you should be aware of the following:

    - Counseling and rehabilitation assistance are available to all trainees through existing Employee Assistance Programs (EAP) at VA facilities (information on EAP can be obtained from your local Human Resources office).
    - You will be given the opportunity to submit supplemental medical documentation of lawful use of an otherwise illegal drug to a Medical Review Officer (MRO).
    - VA will initiate termination of VA appointment and/or dismissal from VA rotation proceedings against any trainee who is found to use illegal drugs on the basis of a verified positive drug test.
    - Termination and/or dismissal from VA rotation proceedings will be initiated against any trainee who refuses to be tested.

5. Random testing will begin no sooner than 30 days from the date you sign this acknowledgement.

6. Visit the US Office of Personnel Management (OPM) Work-Life webpage for information on Services Available for You, Guidance & Legislation as well as Substance User Disorder. https://www.opm.gov/policy-data-oversight/worklife/employee-assistance-programs/

I acknowledge receiving and reading the notice which states that my position may be designated for random drug testing, and that, if selected, refusal to submit to testing will result in termination and/or dismissal from the VA.

_____

Training Program and Affiliate

_____ _____

Print Name and Date Signed Signature

VA EASTERN COLORADO HEALTH CARE SYSTEM
VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS

00Q-78

(00Q)

PATIENT ABUSE AND NEGLECT

1. PURPOSE: To establish health care system policy and procedures to be followed in cases of alleged or suspected patient or resident abuse and/or neglect.

2. POLICY: It is the policy of the Eastern Colorado Health Care System (ECHCS) that no patient or resident will be mistreated, abused, or neglected in any way by an employee. ECHCS has zero tolerance for patient abuse or neglect.

3. DEFINITIONS:

a. Patient Abuse is defined as an act that involves physical, emotional, psychological, sexual, and/or verbal abuse, including but not limited to:

(1) Intentional omission of care;

(2) Willful violations of a patient's privacy;

(3) Intimidation, harassment, or ridicule of a patient;

(4) Willful physical injury;

(5) Unintended injury as stated above, through employee's course of actions;

(6) Physical striking of a patient;

(7) Inappropriate verbal or insulting behavior, or remarks toward/about a patient;

(8) Abandoning, neglecting or isolating a patient;

(9) Threatening a patient;

(10) Exploiting a patient;

(11) Stealing from, or taking advantage of, a patient with respect to financial gain or other personal matters; and/or

(12) Any action or behavior that conflicts with patient's rights, identified in ECHCS policy 00-14, Patient Rights and Responsibilities.

b. A patient refers to any individual receiving VA care in any setting, venue, or program.

c. A resident refers to any veteran receiving care in a residential program, such as the Community Living Center, Residential Rehabilitation Program, or Domiciliary.

4. RESPONSIBILITIES:

a. The ECHCS Executive Leadership Team (ELT) is responsible for ensuring compliance with this policy by all employees. The ELT is responsible for establishing a ***culture of safety*** and creating a blame-free environment that promotes reporting of unsafe conditions or practices, near misses, and adverse events; ensures that all suspected cases of patient abuse are investigated; reviews all comments regarding the incident and ensures that appropriate actions are taken in cases of substantiated abuse. The ELT is responsible for ensuring a preliminary review of each allegation of abuse is conducted and a timely report of findings is submitted; informing the Director of findings and makes recommendations for further action, as appropriate.

b. Clinical Service Chiefs, Associate Chief Nurses and Supervisors are responsible for ensuring the supervisor immediately initiates a fact-finding, collecting all appropriate information related to the incident, and referring the matter immediately to their associated ELT member, Human Resources, and Quality Management.

c. Supervisors are responsible for:

(1) Annually reviewing this policy with their employees. (Attachment A).

(2) 4.b. above.

(3) When informed of a possible incident of patient abuse or neglect, the Supervisor will notify their chain of supervisory command and a member of the Executive Leadership Team (ELT). If criminal acts or suspected criminal acts occur, the informed Supervisor is to report those events to the VA Police immediately. Failure to report an incident of patient abuse may result in administrative action.

> ***NOTE:*** *The Police will call the VA Office of the Inspector General (OIG) if needed. Of course, all employees have the right to contact OIG.*

(4) The Supervisor/Manager will notify the physician in charge of the patient to ensure the patient receives appropriate treatment, if necessary.

(5) Submit the completed fact-finding to Human Resources and in adherence to Policy 05-12 Disciplinary and Adverse Actions. Administrative Investigation (AI) may need to be delayed while a criminal investigation is active.

d. The VA Police are responsible for investigating and referring criminal acts for prosecution.

e. The Employee is responsible for:

(1) Reporting any suspected or actual incidents of patient abuse and/or neglect to his/her immediate supervisor within one (1) hour of awareness of the event, or immediately to prevent further endangerment of the Veteran.

(2) Becoming familiar with the contents of this policy. Every employee should avoid any act which could be construed as abuse, neglect, or mistreatment of patients.

(3) An employee that witnesses any patient abuse, neglect or mistreatment and does not report it to the proper authority is also subject to disciplinary action based on the seriousness of the offense.

f. Quality Management is responsible for reviewing all fact-finding in collaboration with Human Resources Management Service and the affected Service Chief to determine if the case will be forwarded to the Director for consideration of an AI. Additionally, ensuring that all formally-appointed AIs are coordinated, all board members receive the training required to fulfill their assigned responsibility, and that all substantiated cases of abuse are reported to appropriate officials within the specified time frame.

g. Human Resources is responsible for advising management regarding appropriate administrative action to be pursued.

5. PROCEDURES:

a. Policy understanding and expectations to report:

(1) Human Resources will provide every new employee a copy of this policy at new employee orientation.

(2) The Patient Abuse Statement of Understanding (Attachment A) will be signed by the new employee and filed in the employee's Official Personnel Folder and Competency Assessment file.

(3) Supervisors will re-distribute and/or discuss this policy in a staff meeting and assure that every employee in his/her department signs the Patient Abuse and Neglect Statement of Understanding on an annual basis. The Patient Abuse and Neglect Statement of Understanding will be maintained in the employee's unit six-part Official Personnel Folder and Competency Assessment file.

b. Reporting and investigation of abuse or neglect:

(1) The employee will notify his/her immediate supervisor on duty within one (1) hour of awareness of the event, or immediately to prevent further endangerment of the Veteran.

(2) Employees who become aware of possible abuse or neglect of a patient (After notification to the supervisory chain of command and ELT) will initiate one of the three following procedures within 24 hours: 1) the electronic Joint Patient Safety Reporting (JPRS) electronic tool, 2) call the patient safety Hotline 1-SAFE (7233), or 3) complete a Patient Safety Report form (see Attachment B). The JPRS is the preferred method.

(3) The supervisor will subsequently notify a member of the ELT within one (1) hour of being informed of the alleged abuse or neglect.

(4) Actual or possible criminal acts must be reported to the VA Police without delay. VA Police will initiate a preliminary investigation, and if the act is believed to be felonious, the VA OIG will be notified. If criminal behavior is substantiated, the VA Police and/or the VA OIG will refer the case for prosecutorial review.

(5) If necessary, an Administrative Board of Investigation (AIB) will be conducted in accordance with VHA Handbook 1050.01 VHA National Patient Safety Improvement Handbook; VA Handbook 0700, Administrative Investigations.

(6) Allegations of patient abuse must be investigated by an AIB. Exceptions to the requirement are when the patient is known by the treatment team to use allegations of this nature or the threat of such allegations to manipulate staff and when patient judgement is impaired. If the employee admits to patient abuse, the AIB is discretionary. If, during an AIB, it appears a criminal act occurred or may have occurred, the AIB must be suspended immediately and the matter be referred to VA law enforcement.

(7) The patient's perception of how s/he was treated is seriously considered when determining whether abuse occurred. Even without direct patient input, such as patients with limited cognition, abuse can be substantiated.

6. CONCURRENCES: Deputy Director, Chief of Staff, Associate Director of Patient Care Services, Regional Manager Southern Colorado CBOCs, Associate Directors, Assistant Director, Police Service, Deputy Chiefs of Staff, Chief Nurses, Nurse Managers, Clinical Service Chiefs, Clinical Section Chiefs, Ethics Committee, Health Information Management Section, Human Resources, Quality Management, Patient Safety, Risk Management, Privacy, Human Resources, NNU-Denver, and AFGE.

If there is a conflict between the provisions of this policy and the applicable bargaining unit agreement, the terms of the bargaining unit agreement will prevail. Union Participation should be in accordance with the current contract.

7. REFERENCES:

VHA Directive 1199, Reporting Cases of Abuse and Neglect, November 28, 2017.

VHA Directive 1050.01, National Patient Safety Improvement Handbook, March 4, 2011.

The Joint Commission Edition 2018, Provision of Care, Treatment, and Services (PC.01.02.09) and Right and Responsibilities of the Individual (RI.01.06.03) and Care Treatment and Services (CTS.02.02.05).

ECHCS 00-14 Patient Rights and Responsibilities dated October 3, 2017.

VA Handbook 0700, Administrative Investigations, May 25, 2002.

8. RESCISSION: 00-78 Patient Abuse, 2015

9. REVIEW DATE: April 2021

Sallie A. Houser-Hanfelder, FACHE
Director

Attachments: A - Patient Abuse Statement of Understanding
B – Patient Safety Reporting

PATIENT ABUSE AND NEGLECT STATEMENT OF UNDERSTANDING

Do Not Remove from Official Personnel Folder While Employed at Department of Veterans Affairs, Eastern Colorado Health Care System

This is to certify that I have read and understand the VA policy on Patient Abuse. I understand that abuse, verbal and/or physical, involving VA patients will not be tolerated. I understand that if an allegation of patient abuse is substantiated, I will be subject to appropriate administrative actions, up to and including removal from my position within the health care system.

I also understand that criminal behavior must be reported to the VA Police or the VA Office of Inspector General (OIG) immediately and that substantiated criminal behavior will be referred to the Unites States Attorney or local Prosecutor as appropriate.

Receipt of a copy of ECHCS Policy 00Q-78, Patient Abuse, is hereby acknowledged and will be reviewed/signed annually.

Initial Signatures

_____ _____

Employee's printed name/signature — date

_____ _____

Supervisor's printed name/ signature — date

Annual Signatures

_____ _____

Employee's signature — date

_____ _____

Supervisor's signature — date

Employee's signature	date
Supervisor's signature	date
Employee's signature	date
Supervisor's signature	date
Employee's signature	date
Supervisor's signature	date
Employee's signature	date
Supervisor's signature	date
Employee's signature	date
Supervisor's signature	date

Patient Safety Reporting Options

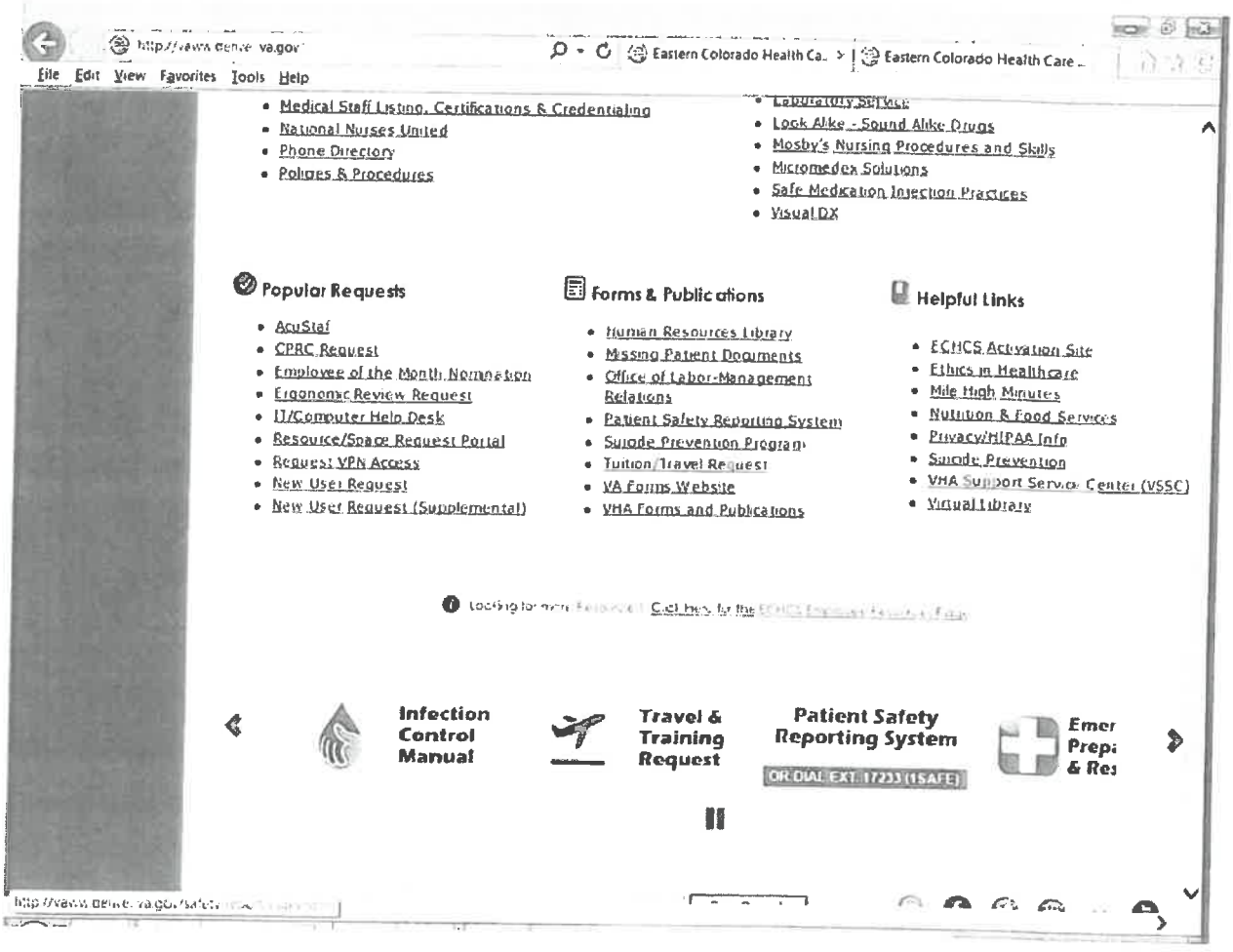
A Patient Safety report is communicated from staff (clinical and non-clinical) to the Patient Safety office regarding observed events or close calls that could harm our patients at any level.

1. JPRS Electronic Reporting System available on the ECHCS homepage
2. Patient Safety Hotline – "1-SAFE" or 17233
3. Paper Patient Safety Report

Available on the ECHCS Homepage

Place in Confidential envelope

Address to "00Q-PS" – delivered to Patient Safety office



QM USE ONLY

SAC: A_____ p____ Close Call____

CODE: M F S R E Tx A D U W O Category/contributing factor: _____

PATIENT SAFETY REPORT

PATIENT NAME: _____

SSN: _____

VS: _____

DATE: _____
TIME: _____
PATIENT STATUS: In__ Out__
UNIT: _____
LOCATION: _____
DIAGNOSIS: _____
MENTAL STATUS: _____
ACTIVITY LEVEL: _____

CATEGORY

MEDICATION: _____
FALL: _____
PARASUICIDE: _____
MISSING: _____
OTHER: _____

DESCRIBE EVENT: ACTUAL EVENT or CLOSE CALL (CIRCLE)

FALLS
Prior fall (documented) YES ___ NO ___

Is patient confused? YES ___ NO ___

Was patient's medical condition the primary contributing factor? (e.g., dizziness, seizure, weakness, arthritis, etc.) YES ___ NO ___

Were any of the following environmental issues the primary contributing factor? (Check only one)

Lighting ___ Toilet height ___
Side-rails ___ Sink height ___
Bed height ___ Flooring ___
Footwear ___ Wet floor ___
Grabbing for an item ___
Other obstacles (describe) _____

Prior to fall patient was ___ in bed ___ in chair ___ ambulating

Does the patient have an IV Heparin lock? YES ___ NO ___
Did the patient fall while in restraints? YES ___ NO ___

PARA-SUICIDE [Attempt/Gesture]

To report a suicide or para-suicidal event, please use the **PROGRESS NOTE** title:

SUICIDAL / PARA-SUICIDAL EVENT

(This form is no longer used for this section of the Patient Safety Report)

MEDICATIONS [Check one in each below]

Type of error
Wrong Dose __ Wrong Route __ Wrong Rate __
Wrong Dosage Form __ Wrong Drug __ Wrong Time __
Wrong Preparation __ Wrong Patient __ Extra Dose __
Omission __ Known Allergy __

Category
Prescribing __ Dispensing __ Administration __
Monitoring effects __ Monitoring systems __

Other related issues
Lack of communication __ Distraction __ Labeling __
Equipment (e.g., BCMA) __ Packaging Design __
Storage __ Look-alike name or table: __
Limited staffing __

MISSING PATIENT *Search Missing Patient Check List*

ETOH/Substance Abuse listed as active diagnosis on current admission YES___ NO___

Safety Risk Assessment Tool Complete YES___ NO___

(In-patient psychiatry patients only) Date _____

Low Risk = voluntarily admitted patient with intact decision-making ability.

High Risk (check one)

[ ] Court appointed legal guardian
[ ] Considered a danger to self or others
[ ] 72-hour Mental Health Hold
[ ] Lacks cognitive ability to make decisions
[ ] Physical or mental impairment that increases risk of harm

[ ] Mental Health Certification __ short-term __ long-

Patient Safety Report
Page 2

DISRUPTIVE BEHAVIOR __Patient to patient __Patient to staff or others __Police Notified
__CODE 3 or 4 called __Other
Type of incident: __Loud demanding __Verbal threat: __Possession of weapon __Violence against property
__Violence against people: a __Touched in threatening way b __Inflicted serious harm requiring medical care
Interventions: __Resolved verbally __Police intervened __Restraints applied __Is person medicated
__Person placed in secure room __Other: _____
Reason for outbreak of behavior: _____
Does patient have previous history of assaults: __yes __no
Was the employee injured during the disruptive behavior/incident? YES __ NO __
Nature of injury: _____
Referred to Employee Health/ER/Private Provider? (Circle) YES __ NO __ N.A. __

OTHER PATIENT SAFETY ISSUES (circle). Check related issues as indicated.
Death Surgical __ Suicide __ Within 24 hours of admission __
Delay in Diagnosis/Treatment due to: Equipment: __ Lab __ Radiology __ Specialty Availability __
Patient Abuse _____
Patient Injury in Restraints or Seclusion: Care planning __ Communication __ Equipment: __
Lack of Observation __ Orientation/training __ Staffing Levels __
Surgical Issue: Consent: __ Communication __ Needle count: __ Sponge count: __ Other __
Transfusion Error: Communication __ Consent: __ Equipment: __ Multiple samples __
Orientation/training __ Reaction not assessed __ Staffing __ Verification __
Wrong Site Surgery: Communication w/ patient: __ Communication w/ surgical team __ Competency __
Credentialing __ Distraction __ Patient assessment: __ Policy for Verification not followed __
Utility or Equipment Failure
Equipment Number _____ Type of Equipment _____
Other Patient Injury: _____

MD NOTIFICATION
Name: _____
Date: _____
Time: _____

REPORTER
Name: _____
Date: _____
Time: _____

PHYSICIAN REPORT [only necessary for actual events, not close calls]

PRINT NAME: _____ SIGNATURE: _____
Date: _____ Time: _____

QUALITY MANAGEMENT COMMENTS: No further action required. ____ RCA Initiated ____

PATIENT SAFETY MANAGER _____ DATE _____

This form must be initiated within 24 hours of the incident and forwarded to the QM office ASAP. Patient-Focused Care staff forward through appropriate channels. The event should be documented in the progress notes. No mention of this form should be made in the medical record nor should this form be placed in the medical or administrative sections of the patient's record. This information is protected in 38 U.S.C. 5705.
DO NOT MAKE COPIES. DVAMC 10-2633

VA EASTERN COLORADO HEALTH CARE SYSTEM
VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS

00-23 (05)

APR 2 8 2016

EMPLOYEE/PATIENT RELATIONSHIPS

1. PURPOSE: To emphasize the employee behavior expectations with regard to the therapeutic relationship between VA Eastern Colorado Health Care System (ECHCS) employees and current or former patients of this facility, and broadens the coverage to all employees.

2. POLICY:

a. Patients who seek treatment from this health care system are considered to be in a vulnerable and disadvantaged position. Patients will be treated with the utmost respect and dignity by all employees. Employees will ensure their interactions with patients, both on and off duty, reflect the highest level of professionalism and therapeutic benefit.

b. All employees, regardless of service or assignment, are expected to limit their contact and interchange with patients to those actions and attitudes that will be beneficial to the patient, or administratively necessary to support the therapeutic environment.

c. Inappropriate social, business and sexual relationships between patients and employees may be considered justification for the formal charge of patient abuse, which may subject an employee to various levels of disciplinary action including dismissal. Other criminal charges and civil actions are also possible under State law.

d. Relationships that predate contact within ECHCS are not ordinarily covered by this policy. However, an attempt to use one's ECHCS position to initiate, resume, intensify, or compromise the pre-existing relationship is covered.

e. Definitions:

(1) Therapeutic Relationships: All relationships between employees and patients for the purpose of or in support of evaluation, treatment, referral, and follow up, along with all services or departments that support their function.

(2) Social/Sexual Relationships: All relationships between an employee and patient for the purpose of pleasure, entertainment, and personal fulfillment not directly associated with the patient's therapeutic regimen. Sexual relationships include but are not limited to kissing, touching, and sexual intercourse.

(3) Business Relationships: Any interactions/transactions between patients and employees which may be licit or illicit for monetary or personal gain including but not limited to gambling, betting, dealing drugs, contraband, financial employment, joint business ventures, bartering or contractual agreements.

(4) Patients: Any patient who receives treatment from the VA whether in an inpatient or outpatient status.

3. RESPONSIBILITY:

a. It is the responsibility of each employee to become familiar with and abide by the contents of this policy. Each employee should avoid any act which could be construed as a violation of this policy, give the appearance of improper action, or could discredit the Department of Veterans Affairs.

b. Human Resources Management Service will ensure that new employees review this policy in New Employee Orientation.

c. Managers who become aware of possible inappropriate social/sexual/business relationships between employees and patients will be responsible for documenting the alleged occurrence and informing their respective Executive Leadership Team (ELT) Member within eight business hours.

4. PROCEDURES:

a. All employees must report their knowledge or suspicion of any incident of inappropriate social/sexual/business relationship between employees and patients to the respective Service Chief within eight business hours of identification of information.

b. Police Service will investigate the alleged occurrence for criminal implications.

c. Alleged violations of this policy will be reported to the Service Chief and fact-finding will be conducted*. Pending the outcome of the fact finding, an employee suspected of violating this policy may be 1) detailed to another area of responsibility within his/her respective service, 2) detailed to another area of the Health Care System, or 3) placed in a non-duty status with pay.

*The fact finding will be concluded within 72 business hours unless extended by appropriate ELT member.

d. Once the fact finding is complete, the ELT will determine the need for either an Administrative Board of Investigation or appropriate administrative action. The Service Chief and a consultant within Human Resources, will recommend the appropriate administrative action to the Director.

5. CONCURRENCES: Human Resources, AFGE Local #2241 and #2430, Organizational Improvement, Fiscal, Regional Manager Southern Colorado CBOCs, Chief of Staff, Associate Chief of Staff CBOCs, Assistant Director, Associate Director, Associate Director Patient Care Services, Privacy, Patient Safety.

If there is a conflict between the provisions of this policy and the applicable bargaining unit agreement, the terms of the bargaining unit agreement prevail. Union participation should be IAW the current contract.

6. REFERENCES:

00-78, Patient Abuse and Neglect

00-14, Patient Rights and Responsibilities

VHA Handbook 1050.01 National Patient Safety Improvement Handbook

7. RESCISSION: 00-23 Employee/Patient Relationships, dated November 10, 2012

8. REVIEW DATE: April 2019

Sallie A. Houser-Hanfelder, FACHE
Director

Department of Veterans Affairs (VA) National Rules of Behavior

1. Background

a. Section 5723(b)(12) of title 38, United States Code, requires the Assistant Secretary for Information and Technology to establish "VA National Rules of Behavior for appropriate use and protection of the information which is used to support Department's missions and functions." The Office of Management and Budget (OMB) Circular A-130, Appendix III, paragraph 3(a(2)(a) requires that all Federal agencies promulgate rules of behavior that "clearly delineate responsibilities and expected behavior of all individuals with access" to the agencies' information and information systems, as well as state clearly the "consequences of behavior not consistent" with the rules of behavior. **The National Rules of Behavior that begin on page G-3, are required to be used throughout the VA.**

b. Congress and OMB require the promulgation of national rules of behavior for two reasons. First, Congress and OMB recognize that knowledgeable users are the foundation of a successful security program. Users must understand that taking personal responsibility for the security of their computer and the VA data that it contains or that may be accessed through it, as well as the security and protection of VA information in any form (e.g. digital, paper), are essential aspects of their job. Second, individuals must be held accountable for their use of VA information and information systems.

c. VA must achieve the Gold Standard in data security which requires that VA information and information system users protect VA information and information systems, especially the personal data of veterans, their family members, and employees. Users must maintain a heightened and constant awareness of their responsibilities regarding the protection of VA information. The Golden Rule with respect to this aspect of an employee's job is to treat the personal information of others the same as they would their own.

d. Since written guidance cannot cover every contingency, personnel are asked to go beyond the stated rules, using "due diligence" and highest ethical standards to guide their actions. Personnel must understand that these rules are based on Federal laws, regulations, and VA Directives.

2. Coverage

a. The attached VA National Rules of Behavior must be signed annually by all VA employees who are provided access to VA information or VA information systems. The term VA employees includes all individuals who are employees under title 5 or title 38, United States Code, as well as individuals whom the Department considers employees such as volunteers, without compensation employees, and students and other trainees. Directions for signing the rules of behavior by other individuals who have access to VA information or information systems, such as contractor employees, will be addressed in subsequent policy. VA employees must initial and date each page of the copy of the VA National Rules of Behavior; they must also provide the information requested on the last page, sign and date it.

b. The VA National Rules of Behavior address notice and consent issues identified by the Department of Justice and other sources. It also serves to clarify the roles of management

and system administrators, and serves to provide notice of what is considered acceptable use of all VA information and information systems, VA sensitive information, and behavior of VA users.

c. The VA National Rules of Behavior use the phrase "VA sensitive information". This phrase is defined in VA Directive 6500, paragraph 5q. This definition covers all information as defined in 38 USC 5727(19), and in 38 USC 5727(23). The phrase "VA sensitive information" as used in the attached VA National Rules of Behavior means:

> All Department data, on any storage media or in any form or format, which requires protection due to the risk of harm that could result from inadvertent or deliberate disclosure, alteration, or destruction of the information. The term includes information whose improper use or disclosure could adversely affect the ability of an agency to accomplish its mission, proprietary information, records about individuals requiring protection under various confidentiality provisions such as the Privacy Act and the HIPAA Privacy Rule, and information that can be withheld under the Freedom of Information Act. Examples of VA sensitive information include the following: individually-identifiable medical, benefits, and personnel information, financial, budgetary, research, quality assurance, confidential commercial, critical infrastructure, investigatory, and law enforcement information, information that is confidential and privileged in litigation such as information protected by the deliberative process privilege, attorney work-product privilege, and the attorney-client privilege, and other information which, if released, could result in violation of law or harm or unfairness to any individual or group, or could adversely affect the national interest or the conduct of federal programs.

d. The phrase "VA sensitive information" includes information entrusted to the Department.

3. Rules of Behavior

a. Immediately following this section is the VA approved National Rules of Behavior that all employees (as discussed in paragraph 2a of Appendix G) who are provided access to VA information and VA information systems are required to sign in order to obtain access to VA information and information systems.

Department of Veterans Affairs (VA) National Rules of Behavior

I understand, accept, and agree to the following terms and conditions that apply to my access to, and use of, information, including VA sensitive information, or information systems of the U.S. Department of Veterans Affairs.

1. GENERAL RULES OF BEHAVIOR

a. I understand that when I use any Government information system, I have NO expectation of Privacy in VA records that I create or in my activities while accessing or using such information system.

b. I understand that authorized VA personnel may review my conduct or actions concerning VA information and information systems, and take appropriate action. Authorized VA personnel include my supervisory chain of command as well as VA system administrators and Information Security Officers (ISOs). Appropriate action may include monitoring, recording, copying, inspecting, restricting access, blocking, tracking, and disclosing information to authorized Office of Inspector General (OIG), VA, and law enforcement personnel.

c. I understand that the following actions are prohibited: unauthorized access, unauthorized uploading, unauthorized downloading, unauthorized changing, unauthorized circumventing, or unauthorized deleting information on VA systems, modifying VA systems, unauthorized denying or granting access to VA systems, using VA resources for unauthorized use on VA systems, or otherwise misusing VA systems or resources. I also understand that attempting to engage in any of these unauthorized actions is also prohibited.

d. I understand that such unauthorized attempts or acts may result in disciplinary or other adverse action, as well as criminal, civil, and/or administrative penalties. Depending on the severity of the violation, disciplinary or adverse action consequences may include: suspension of access privileges, reprimand, suspension from work, demotion, or removal. Theft, conversion, or unauthorized disposal or destruction of Federal property or information may also result in criminal sanctions.

e. I understand that I have a responsibility to report suspected or identified information security incidents (security and privacy) to my Operating Unit's Information Security Officer (ISO), Privacy Officer (PO), and my supervisor as appropriate.

f. I understand that I have a duty to report information about actual or possible criminal violations involving VA programs, operations, facilities, contracts or information systems to my supervisor, any management official or directly to the OIG, including reporting to the OIG Hotline. I also understand that I have a duty to immediately report to the OIG any possible criminal matters involving felonies, including crimes involving information systems.

g. I understand that the VA National Rules of Behavior do not and should not be relied upon to create any other right or benefit, substantive or procedural, enforceable by law, by a party to litigation with the United States Government.

h. I understand that the VA National Rules of Behavior do not supersede any local policies that provide higher levels of protection to VA's information or information systems. The VA National Rules of Behavior provide the minimal rules with which individual users must comply.

i. **I understand that if I refuse to sign this VA National Rules of Behavior as required by VA policy, I will be denied access to VA information and information systems. Any refusal to sign the VA National Rules of Behavior may have an adverse impact on my employment with the Department.**

2. SPECIFIC RULES OF BEHAVIOR.

a. I will follow established procedures for requesting access to any VA computer system and for notification to the VA supervisor and the ISO when the access is no longer needed.

b. I will follow established VA information security and privacy policies and procedures.

c. I will use only devices, systems, software, and data which I am authorized to use, including complying with any software licensing or copyright restrictions. This includes downloads of software offered as free trials, shareware or public domain.

d. I will only use my access for authorized and official duties, and to only access data that is needed in the fulfillment of my duties except as provided for in VA Directive 6001, Limited Personal Use of Government Office Equipment Including Information Technology. I also agree that I will not engage in any activities prohibited as stated in section 2c of VA Directive 6001.

e. I will secure VA sensitive information **in all areas** (at work and remotely) and in any form (e.g. digital, paper etc.), to include mobile media and devices that contain sensitive information, and I will follow the mandate that all VA sensitive information must be in a protected environment at all times or it must be encrypted (using FIPS 140-2 approved encryption). If clarification is needed whether or not an environment is adequately protected, I will follow the guidance of the local Chief Information Officer (CIO).

f. I will properly dispose of VA sensitive information, either in hardcopy, softcopy or electronic format, in accordance with VA policy and procedures.

g. I will not attempt to override, circumvent or disable operational, technical, or management security controls unless expressly directed to do so in writing by authorized VA staff.

h. I will not attempt to alter the security configuration of government equipment unless authorized. This includes operational, technical, or management security controls.

i. I will protect my verify codes and passwords from unauthorized use and disclosure and ensure I utilize only passwords that meet the VA minimum requirements for the systems that I am authorized to use and are contained in Appendix F of VA Handbook 6500.

j. I will not store any passwords/verify codes in any type of script file or cache on VA systems.

k. I will ensure that I log off or lock any computer or console before walking away and will not allow another user to access that computer or console while I am logged on to it.

l. I will not misrepresent, obscure, suppress, or replace a user's identity on the Internet or any VA electronic communication system.

m. I will not auto-forward e-mail messages to addresses outside the VA network.

n. I will comply with any directions from my supervisors, VA system administrators and information security officers concerning my access to, and use of, VA information and information systems or matters covered by these Rules.

o. I will ensure that any devices that I use to transmit, access, and store VA sensitive information outside of a VA protected environment will use FIPS 140-2 approved encryption (the translation of data into a form that is unintelligible without a deciphering mechanism). This includes laptops, thumb drives, and other removable storage devices and storage media (CDs, DVDs, etc.).

p. I will obtain the approval of appropriate management officials before releasing VA information for public dissemination.,

q. I will not host, set up, administer, or operate any type of Internet server on any VA network or attempt to connect any personal equipment to a VA network unless explicitly authorized **in writing** by my local CIO and I will ensure that all such activity is in compliance with Federal and VA policies.

r. I will not attempt to probe computer systems to exploit system controls or access VA sensitive data for any reason other than in the performance of official duties. Authorized penetration testing must be approved in writing by the VA CIO.

s. I will protect Government property from theft, loss, destruction, or misuse. I will follow VA policies and procedures for handling Federal Government IT equipment and will sign for items provided to me for my exclusive use and return them when no longer required for VA activities.

t. I will only use virus protection software, anti-spyware, and firewall/intrusion detection software authorized by the VA on VA equipment or on computer systems that are connected to any VA network.

u. If authorized, by waiver, to use my own personal equipment, I must use VA approved virus protection software, anti-spyware, and firewall/intrusion detection software and ensure

the software is configured to meet VA configuration requirements. My local CIO will confirm that the system meets VA configuration requirements prior to connection to VA's network.

v. I will never swap or surrender VA hard drives or other storage devices to anyone other than an authorized OI&T employee at the time of system problems.

w. I will not disable or degrade software programs used by the VA that install security software updates to VA computer equipment, to computer equipment used to connect to VA information systems, or to create, store or use VA information.

x. I agree to allow examination by authorized OI&T personnel of any personal IT device [Other Equipment (OE)] that I have been granted permission to use, whether remotely or in any setting to access VA information or information systems or to create, store or use VA information.

y. I agree to have all equipment scanned by the appropriate facility IT Operations Service prior to connecting to the VA network if the equipment has not been connected to the VA network for a period of more than three weeks.

z. I will complete mandatory periodic security and privacy awareness training within designated timeframes, and complete any additional required training for the particular systems to which I require access.

aa. I understand that if I must sign a non-VA entity's Rules of Behavior to obtain access to information or information systems controlled by that non-VA entity, I still must comply with my responsibilities under the VA National Rules of Behavior when accessing or using VA information or information systems. However, those Rules of Behavior apply to my access to or use of the non-VA entity's information and information systems as a VA user.

bb. I understand that remote access is allowed from other Federal government computers and systems to VA information systems, subject to the terms of VA and the host Federal agency's policies.

cc. I agree that I will directly connect to the VA network whenever possible. If a direct connection to the VA network is not possible, then I will use VA-approved remote access software and services. I must use VA-provided IT equipment for remote access when possible. I may be permitted to use non–VA IT equipment [Other Equipment (OE)] only if a VA-CIO-approved waiver has been issued and the equipment is configured to follow all VA security policies and requirements. I agree that VA OI&T officials may examine such devices, including an OE device operating under an approved waiver, at any time for proper configuration and unauthorized storage of VA sensitive information.

dd. I agree that I will not have both a VA network connection and any kind of non-VA network connection (including a modem or phone line or wireless network card, etc.) physically connected to any computer at the same time unless the dual connection is explicitly authorized in writing by my local CIO.

ee. I agree that I will not allow VA sensitive information to reside on non-VA systems or devices unless specifically designated and approved in advance by the appropriate VA official (supervisor), and a waiver has been issued by the VA's CIO. I agree that I will not access, transmit or store remotely any VA sensitive information that is not encrypted using VA approved encryption.

ff. I will obtain my VA supervisor's authorization, in writing, prior to transporting, transmitting, accessing, and using VA sensitive information outside of VA's protected environment..

gg. I will ensure that VA sensitive information, in any format, and devices, systems and/or software that contain such information or that I use to access VA sensitive information or information systems are adequately secured in remote locations, e.g., at home and during travel, and agree to periodic VA inspections of the devices, systems or software from which I conduct access from remote locations. I agree that if I work from a remote location pursuant to an approved telework agreement with VA sensitive information that authorized OI&T personnel may periodically inspect the remote location for compliance with required security requirements.

hh. I will protect sensitive information from unauthorized disclosure, use, modification, or destruction, including using encryption products approved and provided by the VA to protect sensitive data.

ii. I will not store or transport any VA sensitive information on any portable storage media or device unless it is encrypted using VA approved encryption.

jj. I will use VA-provided encryption to encrypt any e-mail, including attachments to the e-mail, that contains VA sensitive information before sending the e-mail. I will not send any e-mail that contains VA sensitive information in an unencrypted form. VA sensitive information includes personally identifiable information and protected health information.

kk. I may be required to acknowledge or sign additional specific or unique rules of behavior in order to access or use specific VA systems. I understand that those specific rules of behavior may include, but are not limited to, restrictions or prohibitions on limited personal use, special requirements for access or use of the data in that system, special requirements for the devices used to access that specific system, or special restrictions on interconnections between that system and other IT resources or systems.

3. Acknowledgement and Acceptance

a. I acknowledge that I have received a copy of these Rules of Behavior.

b. I understand, accept and agree to comply with all terms and conditions of these Rules of Behavior.

_____ _____

[Print or type your full name] Signature

_____

Date

_____ _____

Office Phone Position Title

Acknowledge and Acceptance of
VA Eastern Colorado Health Care System Policies

I acknowledge that I have received a copy of the following policies and that I understand, accept and agree to comply with all terms and conditions of each document.

1. Local Policy 00Q-78 Patient Abuse and Neglect
2. Local Policy 00-23 Employee/Patient Relationships
3. VA Handbook 6500, Appendix G, Department of Veterans Affairs (VA) Rules of Behavior

_____
Signature

Department of Veterans Affairs

Memorandum

Date: Todays Date

From: DEO, Office of Academic Affiliations (554/A3-145)

Subj: Non-Citizen WOC Appointment for First & Last Name

To: Director, Eastern Colorado Health Care System (554/00)

Thru: Chief Human Resources Officer (554/05)

1. Request approval to appoint First & Last Name , a non-citizen, as without compensation (WOC) affiliate, clinical trainees within the Eastern Colorado Health Care System (ECHCS). The WOC application paperwork will be managed by HRMS.

2. Attempts are always made to fill the training slots with US Citizens; however, there are a limited number of medical trainees available within our affiliation, and would like that this slot be filled with one of the non-citizens who were included in the highly qualified medical student group for the Program Start Date through Program End Date, training program class. No US Citizens are being displaced from training opportunities, with the inclusion of these non-citizens. I therefore, request your approval to appoint First & Last Name , as a Without Compensation (WOC) Trainee under Title 38, U.S.C. 7405(a) (1).

3. All of First & Last Name duties under the WOC appointment will be performed at ECHCS under the supervision of accredited staff and a clinical attending physician.

4. Any VA research will be enhanced by the high level/quality of service this candidate brings to the Medical Center. Further understanding in these areas will expand treatment options and assist in the development of effective strategies to improve the care received by Veterans.

5. This resident holds a Name of Document Permitting Work In USA which expires Document Expiration Date and has been verified.

6. Please refer any questions to Latoya Conner at ext. 15336 or email Latoya.Conner@va.gov. Thank you for your consideration of this request.

_____

Genet D'Arcy, MD

Non-Citizen WOC Appointment Request for First & Last Name

I certify this request meets regulatory compliance.

Concur/Non-Concur

_____

Claudia Blakeley
Chief Human Resources Officer

Approve/Disapprove

_____

Sallie A. Houser-Hanfelder, FACHE

VERIFICATION OF CERTIFICATE OF NATURALIZATION

Date: _____

I personally cited the Certificate of Naturalization for:	
Date of Birth:	
Place of Birth:	
Certificate Number:	
INS Registration Number:	
Issued By:	INS
On:	

_____
HUMAN RESOURCES REPRESENTATIVE

DEPARTMENT OF VETERANS AFFAIRS
EASTERN COLORADO HEALTH CARE SYSTEM
Rocky Mountain Regional VA Medical Center
1700 North Wheeling Street
Aurora, Colorado 80045
303-399-8020

COURTESY FINGERPRINT REQUEST FORM

If you are completing fingerprints outside of the Rocky Mountain Regional VA Medical Center please complete this form and present it to the VA office that will take your fingerprints.

Name First M.I. Last	First Name, M.I. and Last Name
Social Security Number Last Four	XXX-XX- Last 4 Digits
Date of Birth	MM/DD/YYYY
SON	**1821**
SOI	**VAK7**

AGENCY ACCOMPLISHING FINGERPRINTS

Name:

VA Location: **Date:**

Phone Number:

AGENCY USE ONLY:

E-mail or fax this form once the courtesy fingerprints have been submitted to OPM to:
Fax: 720-723-6025 or E-mail: Beverly.Bone@va.gov Alternate: Andrew.Prokop@va.gov

Note: The Collection of PII Data is for Official Use Only and is in accordance with VA Directive 6609.

If you have any questions regarding this request, please contact either Beverly Bone at 720-723-4823, Andrew Prokop 720 723 4836 or Merrill Albertson 720 723 4837

Thank you,

Beverly Bone
HR Specialist/WOC-Fee Basis Coordinator
Eastern Colorado Health Care System